



Patient Intake Form

Patient Name: _____

Date: _____

List main health issues in order of concern

Date of Birth: _____

1. _____
2. _____
3. _____
4. _____

Age: _____

Name any other physicians you are currently under the care of:

Physician: _____

Phone Number: _____

Physician: _____

Phone Number: _____

Physician: _____

Phone Number: _____

When was your most recent lab work run? _____

Family History:

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living						
Age when died						
Reason for death						
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N
Obesity	Y N	Y N	Y N	Y N	Y N	Y N



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List all surgeries & hospitalizations, including date occurred:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please note when you had any of the following done:

MRI/Cat Scan _____	Last Eye Visit _____
Ultrasound _____	Last Dental Visit _____

Did you receive the normal series of childhood vaccinations? Y N

Choose Yes (Y), No (N), Past (P) regarding the use of the following:

Antacids:	Y N P	
Steroids:	Y N P	
Chewing Tobacco:	Y N P	Age when started: _____
Cigarette/Cigar Smoking	Y N P	How long/How many per day: _____
Does anyone in your household smoke? _____		
Does anyone in your workplace smoke? _____		
Analgesics:	Y N P	
Laxatives:	Y N P	
Coffee:	Y N P	How many cups per day: _____
Soda:	Y N P	Home many ounces per day: _____
Alcohol Addiction:	Y N P	Any Alcohol Treatment: _____
Recreations Drug Use?	Y N P	
Drug Addition:	Y N P	Any Drug Treatment: _____



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Rate your energy on a scale of 1-10, on an average day (1=very low energy, 10=very high): _____

Rate your stress level on a scale of 1-10, on an average day: _____

Rate your overall stress load throughout your life (circle one): Low Moderate High

Rate your mood on an average day (circle one): Poor OK Good Great

How was your health as a child: _____

How many rounds of antibiotics did you have: as a child: _____ as an adult: _____ in the past yr: _____

Rate your opinion of your current overall health (circle one): Poor OK Good Great

If you are troubled by daytime fatigue, what time of day do you experience this? _____

Current Weight: _____ Weight one year ago: _____

Ideal Weight: _____ Highest Adult Weight: _____

Lowest Adult Weight: _____

Medications: Please fill in the following table to the best of your ability:

Medication	Dose	Prescribed By	Using Since	Noted Side Effects



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Supplements: Please fill in the following table to the best of your ability:

Supplement	Dose	Prescribed By	Using Since	Noted Side Effects

Regarding the next long section: Please circle yes (Y) if you have the problem, now (N) if you've the problem, (P) if you had the problem in the past.

SKIN

Rash	Y	N	P	Skin Cancer	Y	N	P
Hives	Y	N	P	Itching	Y	N	P
Psoriasis	Y	N	P	Heavy Perspiration	Y	N	P
Eczema	Y	N	P	Warts/Moles	Y	N	P

HEAD

Headaches	Y	N	P	Head Injury	Y	N	
Dandruff	Y	N	P	Hair Loss	Y	N	P
Vertigo/Dizziness	Y	N	P	Hair Dry	Y	N	P

NOSE

Chronic Congestion	Y	N	P	Nosebleeds	Y	N	P
Frequent Colds	Y	N	P	Post Nasal Drip	Y	N	P
Seasonal Allergies	Y	N	P	Polyps	Y	N	P



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EYES

Dry/Watery	Y	N	P	Dark Under Lids	Y	N	P
Double Vision	Y	N	P	Cataracts	Y	N	P
Glaucoma	Y	N	P	Styes	Y	N	P

MOUTH/THROAT

Canker Sores	Y	N	P	Odd Taste in Mouth	Y	N	P
Cold Sores	Y	N	P	Chronic Dry Mouth	Y	N	P
Sore Throat	Y	N	P	Swollen Glands	Y	N	P
Gum Disease	Y	N	P	Chronic Hoarseness	Y	N	P

RESPIRATORY

Cough	Y	N	P	Wheezing	Y	N	P
Shortness of Breath	Y	N	P	TB	Y	N	P
With Exertion	Y	N	P	Bronchitis	Y	N	P
Lying Down	Y	N	P	Pneumonia	Y	N	P
Sitting	Y	N	P	Asthma	Y	N	P

CARDIOVASCULAR

High Blood Pressure	Y	N	P	High Cholesterol	Y	N	P
Low Blood Pressure	Y	N	P	Heart Murmur	Y	N	P
Arrhythmia	Y	N	P	Palpitations	Y	N	P
Edema	Y	N	P	Chest Pain	Y	N	P

URINARY TRACT

Incontinence	Y	N	P	Discharge	Y	N	P
Urgency	Y	N	P	Blood	Y	N	P
Frequent Infection	Y	N	P	Kidney Stones	Y	N	P

If you are up in the night to urinate, how many times ? _____



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GASTROINTESTINAL

Heartburn	Y	N	P	How often do you have a BM ?	_____
Indigestion	Y	N	P	Recent BM change ?	_____
Bloating	Y	N	P	Constipation/Diarrhea	Y N P
Nausea	Y	N	P	Hemorrhoids	Y N P
Vomiting	Y	N	P	Gallbladder disease	Y N P
Change in Appetite	Y	N	P	Ulcerative disease	Y N P

MALE GENITALIA

Testicular Pain/Swelling	Y	N	P	Sexually Active	Y N P
Hernia	Y	N	P	STD	Y N P
Discharge	Y	N	P	Prostate Disease/Symptoms	Y N P
Impotency	Y	N	P	Do you perform testicular exams ?	_____

FEMALE GENITALIA

Age periods began?	_____	How often period occurs:	_____
How long periods last?	_____	Heavy menstrual bleeding	Y N P
Menstrual Cramping	Y N P	Food Cravings	Y N P
PMS	Y N P	Times Pregnant ?	_____
How many births?	_____	Miscarriages:	_____
Last pap:	_____	Abnormal paps	_____
When:	_____	Menopause since what age?	_____
Sexually active	Y N P	Healthy Libido	Y N P
Vaginal dryness, itching	Y N P	STD	Y N P
Pain with intercourse	Y N P	Vaginitis	Y N P

Do you perform breast self-exam? _____

What forms of birth control do you currently use and what forms have you used in the past?



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MUSCULOSKELETAL

Weakness	Y	N	P	Arthritis	Y	N	P
Stiffness	Y	N	P	Leg Cramps	Y	N	P
Tremors	Y	N	P	Pain	Y	N	P

NERVOUS SYSTEM

Paralysis	Y	N	P	Sciatica	Y	N	P
Numbness/Tingling	Y	N	P	Carpal Tunnel	Y	N	P
Seizures	Y	N	P	Fainting	Y	N	P

MENTAL EMOTIONAL

Depression	Y	N	P	Anger/Irritability	Y	N	P
Suicidal	Y	N	P	High String/Tense	Y	N	P
Anxiety	Y	N	P	Fear/Panic	Y	N	P
Eating Disorder	Y	N	P	Psychiatric Hospitalization	Y	N	P

Exercise

How often do you exercise? _____ For how long? _____

What type of exercise? _____

Diet

List a typical day's diet:

Breakfast:

Lunch:

Snacks:

Dinner:

Snacks:

Beverages (what and how much):



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Do you follow any particular diet (vegan, vegetarian, raw, etc)? _____

Circle any that apply:

Skip breakfast

2 meals per day

Graze

Eat on the run

Eat Constantly

Crave Sugar

Crave Salt

How often do you eat in restaurants?

Which restaurants do you eat in?

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____



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Social Life:

Stress Level: 1 2 3 4 5 6 7 8 9 10

What are your major sources of stress: _____

What is your occupation: _____

Hours worked per week: _____

Do you enjoy your work? _____

Quality of significant relationship: _____

Additional Notes:

Largest health concern: _____

How does this limit you the most: _____

How committed are you to making healthy changes to address this health concern? _____

Additional notes to the doctor: _____
